support and focused behavioral interventions in 10 7-minute calls over four months by specially trained primary care nurses and peer support; telephone and in-person supportive contacts by trained Health Plan members recovered from depression. Primary outcome measures were the Hamilton Rating Scale for Depression, Beck Depression Inventory, Mental and Physical Functioning, Short Form 12, and treatment satisfaction and medication adherence questionnaires.
RESULTS: Nurse-based telehealth patients with or without peer support more often experienced 50% improvement on the Hamilton at 6 weeks (50% vs. 37%, P = .01) and 6 months (57% vs. 38%, P = .003), and on the Beck at 6 months (48% vs. 37%, P = .05), and greater quantitative reduction in symptom scores on the Hamilton at 6 months (10.4 vs. 8.1, P = .006). Telehealth care improved mental functioning at 6 weeks (47.1 vs. 42.6, P = .004) and treatment satisfaction at 6 weeks (4.41 vs. 4.17, P = .004) and 6 months (4.20 vs. 3.94, P = .001). Medication adherence was the same in all groups, and adding peer support to telehealth care did not improve the main outcomes.
CONCLUSION: Nurse Telehealth Care improves clinical outcomes of antidepressant treatment, improves patient satisfaction, and fits well in primary care. The nurse telecare program has been implemented in Maine, Ohio and Southern California.

PMH6

RISK OF DIABETES FOR INDIVIDUALS WITH SCHIZOPHRENIA TREATED WITH ANTIPSYCHOTICS

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OBJECTIVES: To assess the incidence of diabetes for individuals with schizophrenia treated with antipsychotics.
METHODS: Retrospective analysis of a large, geographically diverse claims database of insured individuals identified 815 enrollees aged 18 to 64 who: (1) were diagnosed with schizophrenia; (2) were initiated on typical (n = 353) or atypical (n = 462) antipsychotics between October 1, 1996 and December 31, 1998; (3) had no use of any antipsychotics six-month prior-initiation; and (4) had no diagnosis of diabetes and/or no use of antidiabetics in the year prior. New onset diabetes was defined as either two diagnoses for diabetes (ICD9 250.xx) or prescription for antidiabetics in the year post-initiation. Logistic regressions were used to compare the odds of incidence of diabetes, controlling for demographics and prior-medical comorbidities.
RESULTS: The probability of becoming diabetic was not significantly different for atypical cohort compared to typical cohort (odds ratio = 2.533; p = 0.088) or for olanzapine cohort versus typical cohort (odds ratio = 1.093, p = 0.900). Risperidone-treated patients had significantly higher incidence of diabetes compared to those treated with typicals (odds ratio = 4.362, p = 0.016). Olanzapine compared to risperidone cohort was associated with a significantly lower incidence of diabetes (odds ratio = 0.277, p = 0.050).
CONCLUSIONS: The incidence of diabetes was similar for individuals with schizophrenia receiving treatment with atypical compared to typical antipsychotic agents. Additionally, individuals receiving treatment with olanzapine compared to risperidone had a lower incidence of diabetes.

PMH7

OUTCOMES AND COST OF TREATMENT WITH RISPERIDONE VERSUS OLANZAPINE AMONG PATIENTS WITH CHRONIC SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDERS

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OBJECTIVES: To estimate clinical outcomes and associated cost of care of treatment with risperidone versus olanzapine in patients with chronic schizophrenia or schizoaffective disorders up to one year following therapy initiation.
METHODS: A Markov model was developed to estimate the number of patients who experience side effects (i.e., extrapyramidal symptoms [EPS], prolactin-related disorders, weight gain, and diabetes) of antipsychotic therapies, relapse of psychiatric symptoms as well as discontinuation of antipsychotic therapy following these events at one year; associated costs of care were also calculated. Parameter estimates were based on findings from a randomized, controlled, clinical trial of risperidone and olanzapine and other published and unpublished sources. Analyses were undertaken using second-order Monte Carlo simulation techniques with 10,000 individual trials.
RESULTS: The expected number of patients remaining on initial therapy at one year was higher for risperidone (76.3% versus 44.7% for olanzapine); the expected number of months on therapy was lower for olanzapine (8.0 vs. 10.5 for risperidone). Therapy discontinuation was primarily driven by patients experiencing increases in body weight exceeding 5 kg since therapy initiation. Expected mean total costs per month on therapy were 8% higher for olanzapine ($2,198 vs. $2,033 for risperidone).
CONCLUSIONS: Therapy discontinuation at one year was lower for risperidone than for olanzapine. Expected costs of care per month of therapy were also lower.